Patient Safety in the Commonwealth of Massachusetts: Current Status and Opportunities for Improvement

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RAND project

- Characterize the patient safety landscape in Massachusetts
  - Interviews with expert observers

Background	Interviewed
Academic expert	5
Health care organization	18
Independent quality and safety advocacy organization	12
Patient or caregiver	3
Payer and purchaser	3
Total	**41**

Patient safety in Massachusetts

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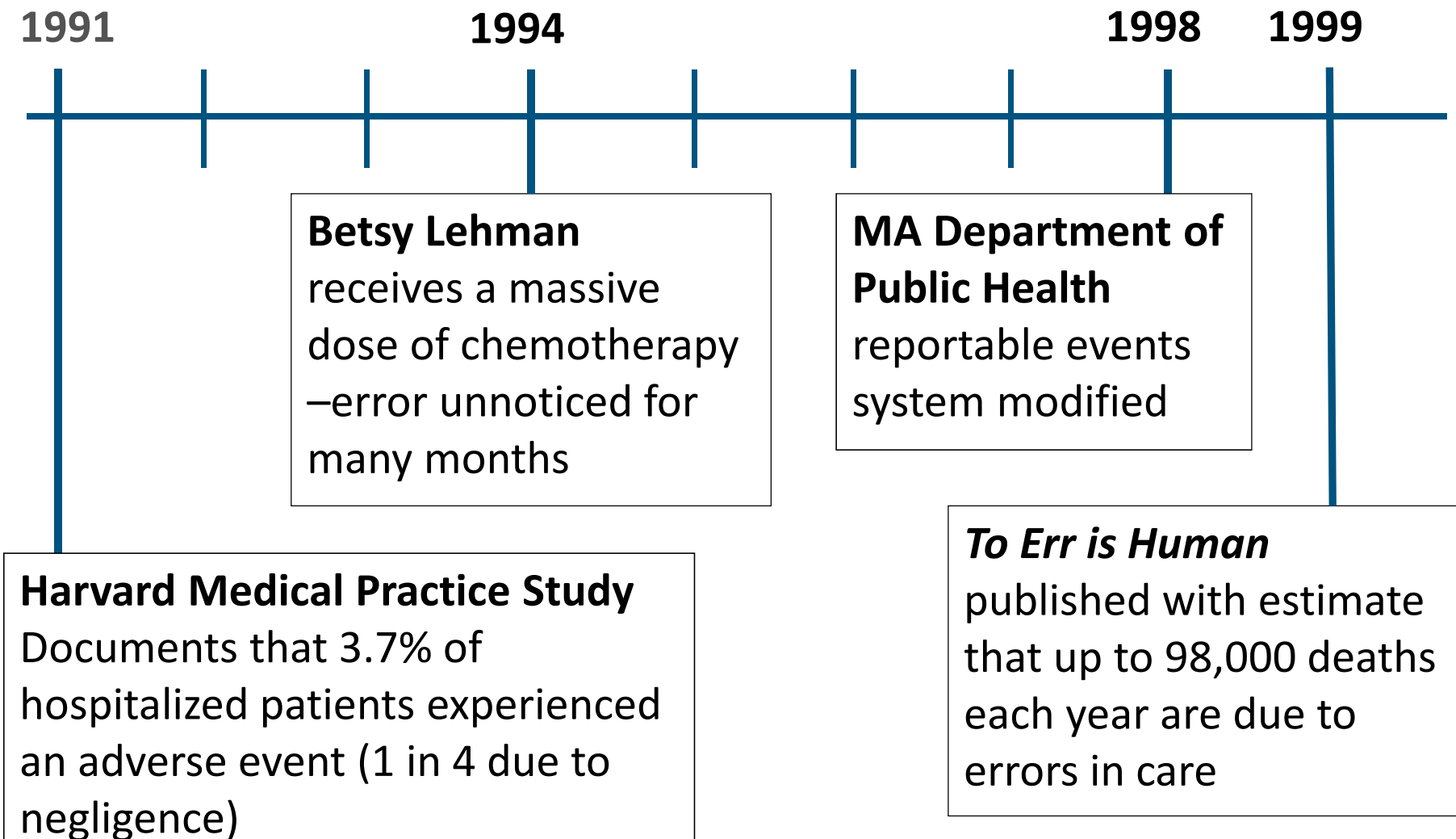
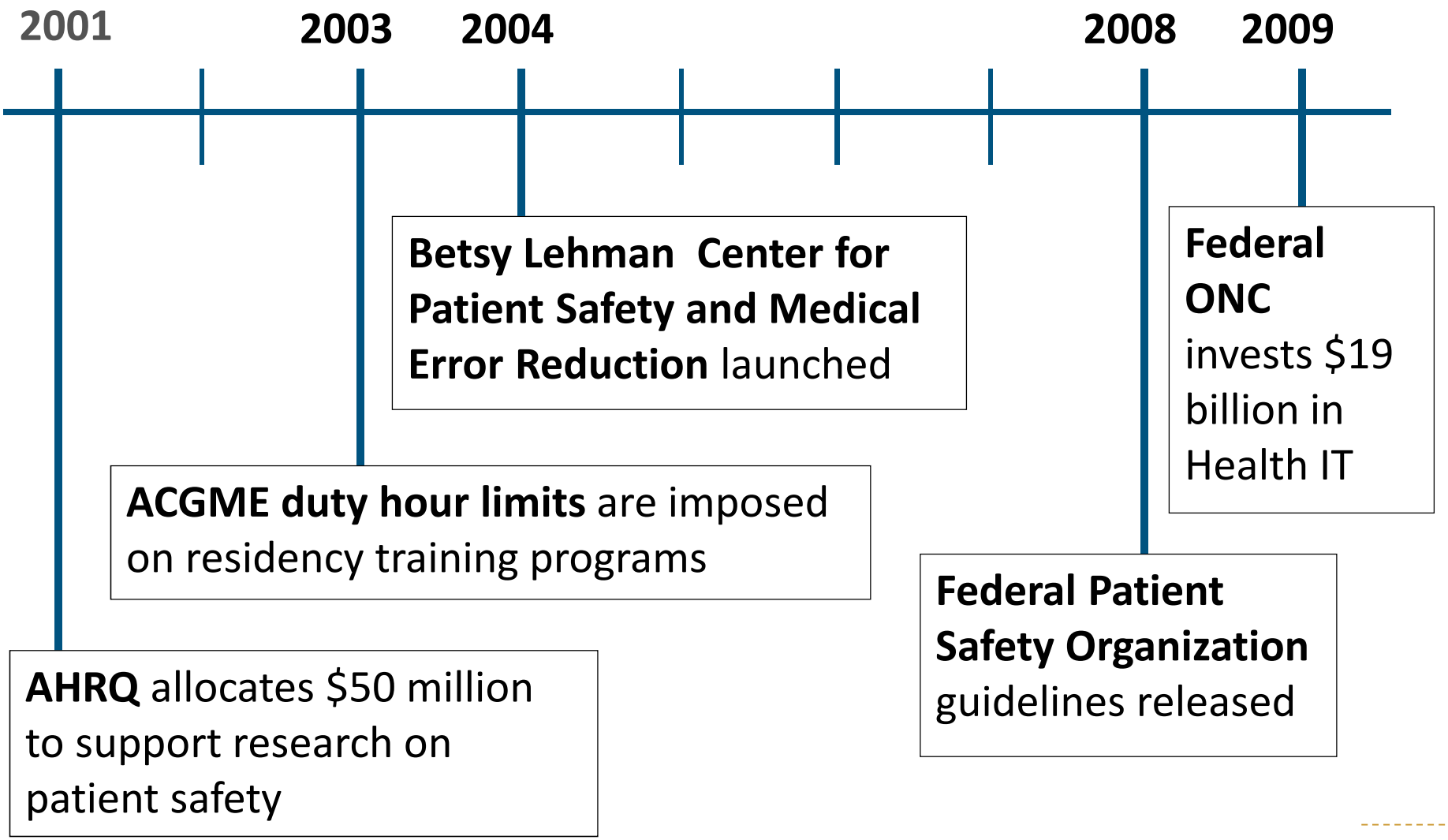


Patient safety in Massachusetts



Massachusetts data on safety

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Hospitalized patient had an adverse event during care[1]	19%
On post-discharge survey, hospitalized patient reported an adverse event [2]	23%
ICU patients who had an adverse event[3]	20%
Patients who reported an adverse drug event in primary care practices[4]	25%

[1]Forster et al, 2003; [2]Weissman et al, 2008; [3]Rothschild et al, 2005, [4]Gandhi et al, 2003

Two widely-shared views

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Awareness of patient safety among health care providers is higher than at any time in the past

Nearly all of the advances in patient safety have occurred in hospitals

What types of safety risks do expert observers describe?

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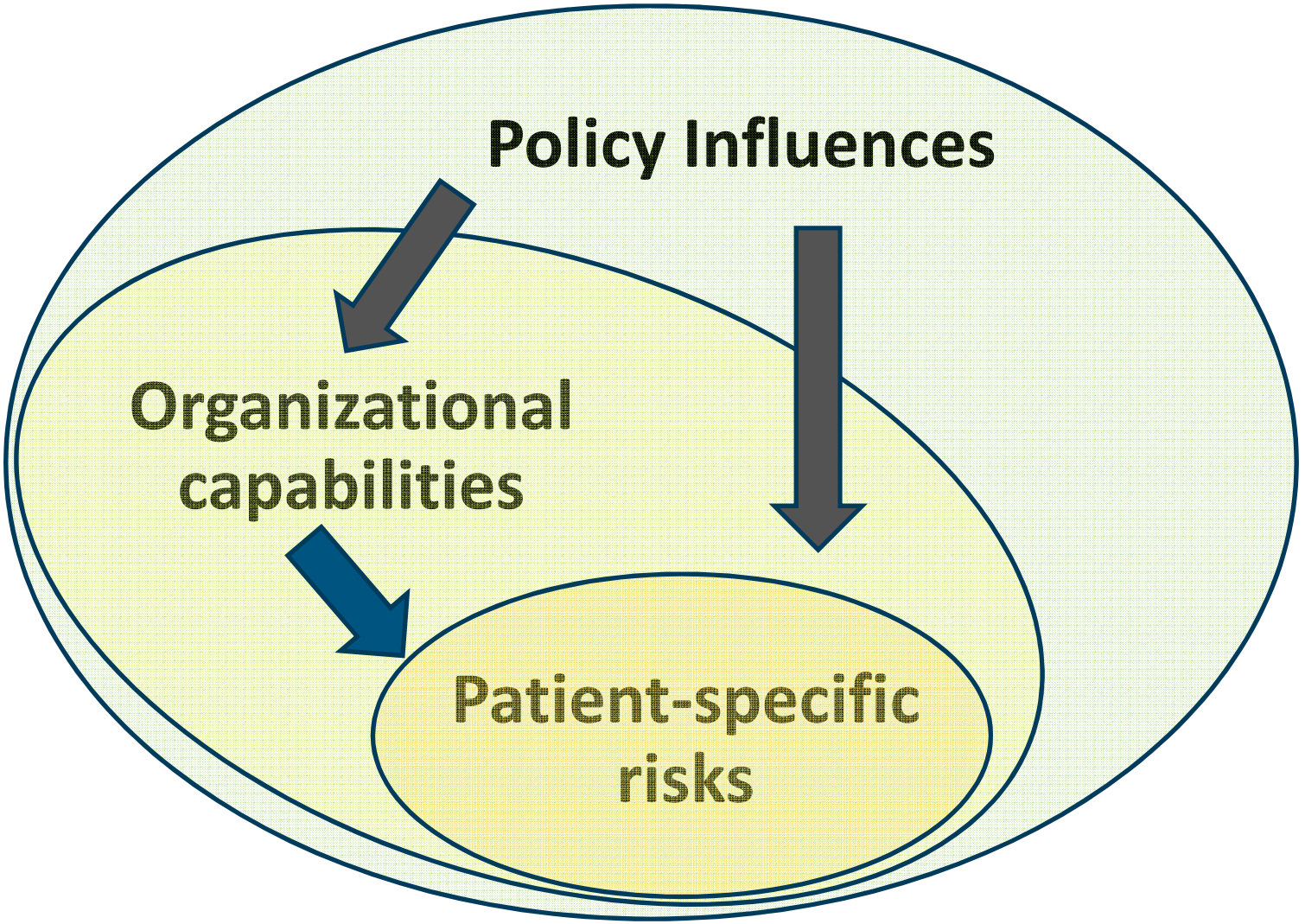

Leading patient-specific safety risks according to expert observers

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- Health care-associated infections
- Medication errors
- Surgical risks
- Falls
- Pressure ulcers

These risks can be reduced

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CPOE in a tertiary hospital[1]	55% decrease in serious medical errors
Pharmacist participation on rounds[2]	66% decrease in preventable ordering ADEs
Bar-code eMAR in a tertiary hospital[3]	41.4% decrease in med administration errors
Fall prevention training program[4]	Fall rate decreased from 16.1% to 9.0%

[1]Bates et al, 1998; [2]Leape et al, 1999; [3]Poon et al, 2010; [4]Bonner et al., 2007

Risks related to organizational characteristics and capabilities

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- Lack of patient safety culture
- Failure to provide patient-centered care and engage patients and caregivers
- Health information technology
- Non-standardized care
- Lack of leadership focus on patient safety
- Limited workforce availability and capability

Policy influences

- Payment policy incentives
- Lack of a coherent reporting program
- Poorly implemented regulatory oversight and accreditation programs

Frontiers of patient safety

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- Enhancing coordination of care
- Reducing diagnostic error
- Gathering data on safety in settings outside the hospital

Questions raised by our study

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- How should actions that can make care safer be prioritized and coordinated among participating organizations and professionals?
- How should measurement and reporting be used?
- How can alignment be achieved between federal requirements, accreditation standards, state regulations, and organizational policies?
- How should patients, caregivers, and the public be engaged in patient safety?


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